**ELITE COGNITION NEW CLIENT REFERRAL**

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| Referral Date: |
| Program Making Referral  CCS CLTS DD CCF PS OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Service Facilitator/ Case Manager Information | |
| Name: | Agency: |
| Address: | Phone Number: |
| Email: | Fax: |

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| Client/Consumer Information | |
| Client’s Full Name: | Date of Birth:  Current Age: |
| Client’s Gender: | Email: |
| Address: | Phone Number: |
| Diagnosis: (List all) | |
| Does this individual have a history of suicidal ideation/ previous suicide attempts?  Yes  No Unknown | Does this individual have a crisis or behavioral plan in place? Crisis Behavioral  Yes  No Unknown |
| \*If this client is a minor or has a power of attorney- please complete the following: | |
| Guardian/Parent’s Name: | Phone Number: |
| Address (if different than client): | Email: |

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| Service Need(s) | |
| Medication Management (non-prescriber) | Physical Health Monitoring |
| Individual Skill Development & Enhancement | Employment Related Skill Training |
| Individual and/or Family  Psychoeducation | Wellness Management and Recovery/  Recovery Support Services |
| Psychotherapy | Diagnostic Assessment:  BSP (Behavioral Support Plan)  Safety Protocol  LEP (Law Enforcement Protocol) (Home/Community)  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Client would prefer working with provider that is: Female  Male  No Preference | |
| **Description of presenting barriers, needs, wants, goals and strengths.** ***(Be as specific as possible and use back of form if more space is needed).*** If “Yes” to Consumer questions above, please give additional information in this section. | |